580-1
Federal regulations provide, in pertinent part, that:

(b) A state plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility. (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

581-1
"Contract" means the written agreement entered into between a health care service plan (as defined in §1345, Health and Safety Code) and the Department and approved by appropriate state agencies to provide health care services to members under the provisions of the Waxman-Duffy Pre-paid Health Plan (PHP) Act, §14200, et seq., Welfare and Institutions Code. (§53108)

581-2
"Disenrollment" means the process by which a member's entitlement to receive services from a PHP is terminated. (§53114)

581-3
Except as provided in §53440, PHP membership shall continue indefinitely after enrollment. Membership shall be contingent upon the member's retention of Medi-Cal eligibility as well as eligibility for enrollment in the plan under the terms of the plan contract. (§53426)

581-4
Each prepaid health plan shall establish and maintain a procedure for submittal, processing and resolution of all member complaints. This section provides that such procedures shall be approved by the Department and shall provide for the processing of disenrollment requests through the grievance procedure. (§53260(a))

State law provides that the enrollment of a Medi-Cal beneficiary in a prepaid health plan shall not be terminated except for loss of eligibility, for good cause as determined by the Department, or at the request of the beneficiary. (Welfare and Institutions Code (W&IC) §14412(a))

583-1
State law permits the Director of the CDHS to designate any benefit or service included in the Medi-Cal Program, at state option under federal Medicaid rules, as a covered benefit only when provided by a Medi-Cal managed care plan to a

Medi-Cal enrollee of the plan. (Welfare and Institutions Code (W&IC) §14131.15(a))

Where benefits and services have been designated by the Director under the above paragraph, beneficiaries who are eligible to enroll in and reside in the service area of a managed care plan, and who desire coverage for such benefits and services, must enroll in a Medi-Cal managed care plan to receive them. These beneficiaries shall, to the maximum extent permitted under federal law, remain enrolled in the plan. (W&IC §14131.15(b))

584-1
Enrollment in GMC is mandatory for eligible beneficiaries who meet all of the following criteria:

1. Are eligible for full scope Medi-Cal;

2. Have a zero SOC;

3. Do not qualify to select an alternative to GMC, under §53923.5;

4. Are eligible for AFDC, or linked to AFDC, to Foster Care, or to the MI program for children under age 21.

(§53906(a))

584-2
The CDHS or the GMC enrollment contractor shall mail an enrollment form and GMC plan information to each eligible beneficiary described in §53906(a). The mailing shall include GMC options presentation information and instructions to enroll in a GMC plan within thirty days of the postmark date on the mailing envelope. (§53921(c)) Each eligible beneficiary described in §53906(a) shall enroll in a GMC plan within thirty days of receipt of an enrollment form with instructions from the department or the GMC enrollment contractor to select a GMC plan. Under Subsection (1), in the event an eligible beneficiary described in §53906(a) does not enroll in a GMC plan within thirty days, the GMC enrollment contractor shall assign the eligible beneficiary to a GMC plan, in accordance with §53921.5. (§53921(d))

584-3
Each eligible beneficiary, prior to or upon either signing an enrollment application or being assigned to a GMC plan in accordance with §53921.5, shall be informed in writing by the department or the GMC enrollment contractor of at least the following:

(1) There will be a 15 to 45 day processing time between the date of application and the effective date of enrollment in a GMC plan.

(2) Until GMC plan enrollment is effective, the beneficiary may receive Medi-Cal covered health care services from any Medi-Cal provider licensed to provide the services.

(3) An alternative to GMC plan enrollment exists.

(4) Disenrollment from certain GMC plans, specified in §53925.5, is restricted during the second through sixth month of enrollment.

(§53926.5(a))

584-4
Each GMC plan shall provide in writing, in addition to those items of information required by W&IC §14406, the following to each member within seven days after the effective date of enrollment in the plan:

(1) The effective date of enrollment.

(2) A description of all available services and an explanation of any applicable service limitations, exclusions from coverage or charges for services.

(3) The name, telephone number and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days or be assigned to one.

(4) An enrollment/disenrollment form and an explanation that it must be used to disenroll from the GMC plan, in the event disenrollment is requested by the member.

(5) Information concerning non-medical transportation available to the beneficiary under the Medi-Cal program, or offered by the GMC plan, if applicable, and how to receive it.

(§53926.5(b))

584-5
Each eligible beneficiary enrolling in a GMC plan shall enroll in one dental plan and either one PHP or one PCCM plan. (§53921(e))

584-6
The GMC enrollment contractor shall assign an eligible beneficiary described in §53906(a) to a GMC plan, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a PHP or PCCM plan and

a dental plan within thirty days of receiving an enrollment form pursuant to §53921(c).

(2) In the event a member requests and is granted disenrollment from a GMC plan (pursuant to §53925.5) but does not select a different GMC plan (pursuant to §53925.5) in which to enroll: Unless that member was granted approval by the GMC enrollment contractor to receive health care services through the fee-for-service Medi-Cal program (pursuant to §53923.5).

(§53921.5(a))

584-7
No member who is assigned to a GMC plan under §53921.5 shall be denied a request for disenrollment if all primary health care services through that assigned GMC plan are more than 10 miles from the beneficiary's residence. (§53922.5(a))

584-8
An eligible beneficiary specified in §53906(a) who meets the requirements of (a) or (b) may request from the GMC enrollment contractor an alternative to GMC plan enrollment.

(a) An eligible beneficiary who is an Indian, is a member of an Indian household, or has written acceptance from an Indian Health Service program facility to receive health care services through that facility, may, as an alternative to GMC plan enrollment and upon request, choose to receive health care services through an Indian Health Service program facility.

(b) An eligible beneficiary who is receiving treatment or services for a complex medical situation from a physician who is participating in the Medi-Cal program, but is not a contracted provider of any GMC plan, may request continued fee-for-service Medi-Cal for the purposes of continuity of care. The department may approve continued treatment under the fee-for-service Medi-Cal program for any eligible beneficiary whose diagnosis or treatment needs are verified in writing by the beneficiary's Medi-Cal provider and who meets one of the criteria below in 1 though 3 for continued fee-for-service Medi-Cal.

(1) The eligible beneficiary is under the care of a physician specialist:

(A) For treatment of a condition that is within the specialist's scope of practice, pursuant to the Business and Professions Code;

(B) That specialty is not practiced by any physician within the available providers of any GMC plan; and

(C) That specialist is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(2) The eligible beneficiary is in a complex, high risk medical treatment plan:

(A) Under the supervision of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan; and

(B) May experience deleterious medical effects if that treatment were to be disrupted by leaving the care of that physician to begin receiving care from a GMC plan physician.

(3) The eligible beneficiary is a woman who is pregnant and under the care of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(c) Any eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(1) or (2) may remain with that fee-for-service physician only until the medical condition has stabilized to a level that would enable the eligible beneficiary to change physicians and begin receiving care from a GMC plan physician without deleterious medical effects. An eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(3) may remain with that physician through delivery and the end of the month in which ninety days post-partum occurs.

(§53923.5)

584-9
State regulations require that:

(a) Each GMC plan shall have a mechanism in place and approved in writing by the department to ensure that each member is assigned to a primary care provider, by either:

(1) Allowing each member to select a primary care provider from the GMC plan's network of affiliated providers, if the member chooses to do so; or

(2) Assigning a primary care provider to each member within forty days from the effective date of enrollment, if the member does not select one within the first thirty days of the effective date of enrollment in the GMC plan.

(A) Assignment conducted pursuant to (a)(2) shall meet both 1 and 2:

1. The member shall be assigned to a primary care provider no more than 10 miles from the beneficiary's residence.

2. If available within the GMC plan, the member shall be assigned to a primary care provider who is or has office staff who are linguistically and culturally competent to communicate with the member or have the ability to interpret in the

provision of health care services and related activities during the member's office visits or contacts, if the language or cultural needs of the member are known to the GMC plan.

(b) Any member dissatisfied with the primary care provider selected or assigned shall be allowed to select or be assigned to another primary care provider. Each GMC plan shall assist its members in changing primary care providers if that change is requested by the member. Any GMC plan physician or dentist dissatisfied with the professional relationship with any member may request that the member select or be assigned to another primary care provider.

(§53925)

585-1
The Two-Plan Model Managed Care Program exists, in the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. (§53800(a))

Each plan in such a designated region shall, in pertinent part:

1. Agree to provide or arrange for the provision of, to the extent allowed by federal and state law, the scope of Medi-Cal program benefits set forth by contract to eligible beneficiaries who select or are assigned to the plan.

2. Provide readily available and accessible health care services and utilize preventive health care programs.

3. Case manage members' utilization of health care services.

4. Inform eligible beneficiaries about nonmedical transportation services that may be available under the Medi-Cal program, including the conditions under which such services will be provided by the plan, and how to request those services which the plan opts to provide.

(§53840(a))

585-2
In those counties which have adopted the Two-Plan Model:

(a) Enrollment in plans shall be mandatory for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope.

(2) Have been determined to have an SOC equal to zero.

(3) Do not meet the criteria for selecting an alternative to plan enrollment, specified in §53887.

(4) Are eligible for either of the following:

(A) Programs linked to the Aid to Families with Dependent Children (Aid to Families with Dependent Children) program, as described in §1931 of the Social Security Act (42 United States Code §1396) as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; or

(B) The Medically Indigent program for children under age 21, as specified in §50251(a).

(§53845(a))

585-2A
CDHS or the Health Care Options Program shall mail an enrollment form and plan information to each eligible beneficiary described in §53845(a) who does not attend a health care options presentation. The mailing shall include health care options information and instructions to enroll in a plan within thirty days of the postmark date on the mailing envelope. At a minimum, the mailing shall include instructions on how to enroll, how to request an exemption from mandatory enrollment for medical or nonmedical reasons, and how to request a medical exemption certification form. (§53882(c))

Each eligible beneficiary described in §53845(a) shall select a plan within thirty days of receipt of an enrollment form unless a request for an exemption to plan enrollment is submitted to the Health Care Options Program within 30 days of receipt as prescribed in §53887(b), or within thirty days of the postmark date of the health care options information if mailed.

(1) In the event the eligible beneficiary does not select a plan within thirty days, the Health Care Options Program shall assign the eligible beneficiary to a plan, in accord with §53883.

(§53882(d))

585-2B
State regulations regarding the Two-Plan mode provide:

(a) The Health Care Options Program shall assign an eligible beneficiary to a plan within a designated region, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a plan within thirty days of receiving an enrollment form.

(2) In the event a member requests and is granted disenrollment from either plan within that region, but does not enroll in the competing plan, unless that member was granted approval by the department or its designee to receive health care services through the fee-for-service Medi-Cal program.

(3) In the event the competing plan is at capacity, the fee-for-service Medi-Cal option shall be made available.

(b) In carrying out (a), the Health care Options Program shall comply with the assignment requirements contained in §53884.

(§53883)

585-2C
In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider the Plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the Program. (§53884(b)(3))

585-3
In Two-Plan Model counties:

(b) Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope.

(2) Have been determined to have an SOC equal to zero.

and

(3) Are eligible for any of the following:

(A) The federal Supplemental Security Income program for the Aged, Blind, and Disabled.

(B) The Medically Indigent program for pregnant women, as specified in §50251(b)(3).

(C) The Foster Care Program as described in W&IC §11400 et seq.

(D) The Adoption Assistance Program as described in W&IC §16115 et seq.

(§53845)

585-4A
In a Two-Plan Model, certain eligible beneficiaries may receive fee-for-service Medi-Cal. State regulations provide that:

An eligible beneficiary meeting the criteria specified in §53845(a), who satisfies the requirements in (1) or (2) below, may request fee for service Medi-Cal for up to 12 months as an alternative to plan enrollment by submitting a request for exemption from plan enrollment to the Health Care Options Program as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in §55100(i), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care.

(A) For purposes of this section, conditions meeting the criteria for a complex medical condition include, and are similar to, the following.

An eligible beneficiary:

1. Is pregnant.

2. Is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately postoperative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

3. Is receiving chronic renal dialysis treatment.

4. Has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

5. Has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

6. Has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately postoperative.

7. Has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1. through 6. above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

8. Is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility.

9. Is participating in a pilot project organized and operated pursuant to §§14087.3, 14094.3, or 14490 of the Welfare and Institutions Code.

(§53887(a), effective December 19, 2000)

585-4B
A request for exemption from plan enrollment (in a Two-Plan Model) based on complex medical conditions shall not be approved for an eligible beneficiary who has:

1. Been a member of either plan on a combined basis for more than 90 calendar days.

2. A current Medi-Cal provider who is contracting with either plan.

3. Begun or was scheduled to begin treatment after the date of plan enrollment.

(§53887(a)(2)(B), effective December 19, 2000)

585-6
In the Two-Plan Model:

(a) The Health Care Options Program shall use a combined enrollment/disenrollment form in operating the Health Care Options Program. This form shall be made available at the health care options presentation and at designated sites. The form shall be mailed to a beneficiary within three working days of receiving a telephone or written request for a form.

(b) Plans shall make the form available at the member services departments and shall mail the forms to the beneficiary within three working days of receiving a telephone or written request for a form.

(§53888 as modified effective December 19, 2000)

585-7
In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider, among a number of criteria, that there is a preference for placing family members in the same plan. (§53884(b)(4))

585-8
State regulations provide that:

(a) Each plan (in a Two Plan model) shall ensure that primary health care services provided through the plan are no more than 30 minutes travel time or ten (10) miles travel distance from each member's place of residence, unless the department has approved an alternative time and distance standard.

(b) An eligible beneficiary may voluntarily choose to receive services from a plan service site with a travel time or distance that exceeds the requirements in subsection (a).

(§53885)

585-9
Except for pregnancy, any eligible beneficiary in a Two-Plan Model granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without harmful medical effects, as determined by the beneficiary's treating physician up to 12 months from the date the medical exemption is first approved by the Health Care Options Program. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service Medi-Cal provider through delivery and the end of the month in which 90 days post-partum occurs.

Any extension to the 12-month medical exemption time limit shall be requested through the Health Care Options Program no earlier than 11 months after the starting date of the exemption currently in effect. The Health Care Options Program shall notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary continues to meet the requirements of subsection (a)(2).

(§53887(a)(3) and (4), effective December 19, 2000)

585-10
Exemption from plan enrollment or extension (in the Two-Plan Model) of an approved exemption due to a complex medical condition shall be requested on the "Request for Medical Exemption from Plan Enrollment" form (HCO Form

7101, June 2000). Exemption from plan enrollment or extension of an approved exemption due to a beneficiary's enrollment in a Medi-Cal waiver program, as specified, or a beneficiary's acceptance for care at an Indian Health Service facility, shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO Form 7102, October 2000). The completed request for exemption shall be submitted by mail or fax to the Health Care Options Program by the Medi-Cal fee-for-service provider or the Indian Health Service facility treating the beneficiary. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(§53887(b), effective December 19, 2000)

585-11
In the Two-Plan Model, the Health Care Options Program shall accept and process all completed enrollment and disenrollment requests, including expedited disenrollment requests, from eligible beneficiaries within two working days of receipt if such requests meet the conditions for plan disenrollment specified in §53891.

Approval of enrollment and disenrollment requests is conditioned upon receipt of a fully completed enrollment/disenrollment form and all required supporting documentation.

The Health Care Options Program shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment, as specified in subsection (h) below.

(§53889(e), (f) and (g), effective December 19, 2000)

585-12
Nothwithstanding this article or section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994 except for contracts in county organized health systems.

Nothwithstanding any other provisions of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but not enrolled in a pilot project shall continue to submit billing for CCS services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts.

For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code.

(Welfare and Institutions Code (W&IC) §§14094.3(a), (b) and (e))

585-13
Services (in the California Children's Services Act) mean any or all of the following:

- Expert diagnosis
- Medical treatment
- Surgical treatment
- Hospital care
- Physical therapy
- Occupational therapy
- Special treatment
- Materials
- Appliances and their upkeep, maintenance, care and transportation
- Maintenance, transportation or care incidental to any other services

(Health and Safety Code §123840)

585-14
Each plan shall provide or arrange to provide for all Medi-Cal covered services, unless excluded under the contract, in accordance with the terms and provisions of the contract between the plan and the Department. The scope of services shall include preventive services, case management and emergency care. Each plan shall refer and coordinate for those services that are excluded under the contract, whether or not covered under Medi-Cal, pursuant to the requirements of the contract between the plan and the DHS. (§53851)